



THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF LABOR
DIVISION OF OCCUPATIONAL SAFETY
www.mass.gov/dos

**Application for Waiver of Minimum Wage
for Employees with Disabilities
M.G.L. c. 151, §9 and 455 C.M.R. 2.05(1)(2)**

Pursuant to M.G.L. c. 151, §9 and 455 C.M.R. 2.05(1)(2), the Division of Occupational Safety may issue to any employer of:

- 1) an employee whose earning capacity is impaired by age or physical or mental deficiency or injury,
or
- 2) an employee who is certified by the secretary of health and human services or his designee as a
handicapped person

a certificate authorizing employment at a wage rate less than the established minimum fair wage.

To apply for this annual waiver, the employer must submit this completed application form, along with a fee of one hundred dollars (\$100). The fee must be submitted in the form of a money order or check, payable to the Commonwealth of Massachusetts, in the amount of the entire annual fee. This fee is not refundable in the event that this application is denied.

Please submit the completed application form and application fee to:

**Division of Occupational Safety
Minimum Wage Program
19 Staniford Street, 2nd Floor
Boston, MA 02114**

Your application form and fee should be submitted at least 30 days prior to the requested date of applicability.

If you have any questions regarding this application, please contact
Lisa Price at 617-626-6952 or send email to Lisa.Price@state.ma.us

PLEASE NOTE:

Employers seeking to pay disabled workers less than the federal minimum wage rate must also file for a certificate authorizing such payment from the U.S. Department of Labor.



THE COMMONWEALTH OF MASSACHUSETTS
Department of Labor
Division of Occupational Safety
19 Staniford Street, 2nd Floor
Boston, MA 02114
617-626-6952
Fax: 617-626-6944
DOS Homepage: www.mass.gov/dos

Application for Waiver of
**Minimum Wage for Employees
with Disabilities**
M.G.L. c. 151, §9 & 455 C.M.R. 2.05(1)(2)

Please provide the following information:

1. Name of company/organization: _____
2. Nature of business: _____
3. Telephone number: _____
4. Business address: _____
5. Name of contact person and title: _____
6. If the company/organization has applied for or received a federal certificate which authorizes the employer to pay special minimum wages, please provide the following and skip to question 11:

If the company/organization has filed an initial Application for Authority to Employ Workers with Disabilities at Special Minimum Wages (Federal Form WH-226-MIS), please provide:

- a copy of the Application, including Federal Form WH-226A and all required supporting documentation, and
- a copy of the federal certificate, if received.

If the company/organization has filed for renewal of an existing federal certificate, please provide:

- a copy of the renewal Application, including Federal Form WH-226A and all required supporting documentation, and
- a copy of the current federal certificate.

7. If the company/organization has not applied for or received a federal certificate, please answer questions 8-10.

8. Provide names of the individuals with disabilities, the nature and extent of the disabilities, and the expected start dates. (attach additional sheets if necessary):

9. Provide detailed information about the nature of the work and any time studies that have been conducted (attach additional sheets if necessary):

10. Provide the prevailing or usual wage rate for the work performed and the proposed adjusted hourly rate for the employees with disabilities. Explain how the prevailing rate and adjusted rate were determined (attach additional sheets if necessary):

11. a. Is this the company/organization's first application? Yes / No

b. If this is not the first application, when was the last application made?_____

c. If a previous application was approved, when was the waiver in effect?_____

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Please note: If the waiver application is approved, The Division of Occupational Safety may attach conditions to the granting of the waiver if deemed necessary.

Signature of Applicant:_____

Name of Applicant:_____

Title:_____

Date:_____

Office Use Only

CMS # _____

Check # _____

Date Received _____

New Application / Renewal
Expiration Date _____

Granted / Denied Date _____